**State Plan for Medical Assistance**
**under Title XIX, SSA**
**New Mexico**

Attachment 1.2-B

ORGANIZATION AND FUNCTION UNDER MEDICAL ASSISTANCE DIVISION

The unit responsible for administering the Title XIX program under the Single State Agency in New Mexico is the Medical Assistance Division.

This attachment is organized in two sections. The first provides a brief description of the responsibilities of the division director, the second briefly describes the bureaus and sections of the division and the third is an organizational chart of the division.

## SECTION I

Division Director - The Medical Assistance Division Director directly supervises the bureau chiefs and represents the division in meetings with the Department Secretary, with provider groups, with officials of the federal Health Care Financing Administration, with the claims processing contractor, and with advisory groups. These meetings require 20 to 25 percent of the director's time, with 50 to 55 percent of his time going to division supervision. The remaining time is spent working with other private contractors and coordinating the division's efforts with those of other divisions in the Human Services Department and other state agencies involved in administration of the Medicaid program.

## SECTION II

Program Support Bureau - The Program Support Bureau is responsible for support and programmatic functions within the division, including preparing and administering the budget; planning and evaluating programs; retrospectively reviewing the use of services by Medicaid recipients and bills from health care providers; and ensuring Medicaid is the payer of last resort. The four sections are: Budget and Evaluation; Eligibility; Surveillance and Utilization Review; and Third Party Liability.

A. Budget and Evaluation Section - The Budget and Evaluation Section develops and monitors the division's budget, prepares all fiscal documents, processes contracts, prepares federal reports, monitors inventory reporting, orders supplies and maintains account reports. Planning functions include development of long- and short-range

policies, data analysis, program evaluation, preparation of reports and other technical support as required.

B. Eligibility Section - The Eligibility Section develops and implements Medicaid eligibility policy orginating with federal statute and regulation and state statute and is the division's contact with the computerized eligibility system.

C. Surveillance and Utilization Review - The Surveillance and Utilization Review Section monitors the medical services provided by participating providers and the use of these services by recipients. The claims processing contractor provides SURS with individual medical profiles compiled from claims for comparison to established norms. Deviations are selected for analysis and, in the case of providers, may result in recoupment or referral to peer review, the Office of Inspector General or the Medicaid Fraud Unit. In the case of recipients, over-utilization may result in assignment to the Medical Management Program.

D. Third Party Liability Section - The Third Party Liability Section develops and implements methods of identifying third party medical resources for Medicaid recipients or liable third parties to ensure that Medicaid is the payor of last resort. This effort prevents the Medicaid program from paying for services when the recipient has other insurance; allows the program to collect reimbursement from appropriate insurance carriers in those cases in which payments were made prior to learning of the insurance coverage; and recover funds resulting from litigation and other settlements.

Medical Services Bureau - The Medical Services Bureau is responsible for the daily operation of the Medicaid Program. The bureau oversees processing of Medicaid claims and prior authorization of medical services through two separate contracts and coordinates the work of the contractors with other aspects of the program. The bureau is responsible for writing program policies and regulations relating to medical services; and communicating directly with providers of service and recipients regarding program coverage, payments, special requirements and billing instructions. The bureau also administers the health service aspects of the program, including helping assure patient access to services and promoting health screens for children. The three sections are: Institutional Care, Ambulatory and Program Development.

A. Institutional Care Section - The Institutional Care Section develops and implements policy for all institutional-based services. The staff oversee claims processing, develop utilization review systems, conduct provider training and review expenditures for these services. The services include hospitals, nursing homes, intermediate care facilities for the mentally retarded, home health agencies, hospices, transplants, inpatient and outpatient rehabilitation centers, independently certified physical and occupational therapists, accredited residential treatment centers and several EPSDT services.

B. Ambulatory Care Section - The Ambulatory Care Section is responsible for developing

program guidelines, provider relations and claims payment monitoring for all ambulatory services. Ambulatory services include physicians, podiatrists, psychologists, laboratories, dentists, pharmacies and medical suppliers. The section's functions include provider training, fee schedules, service coordination with other department divisions, other state agencies and providers and the promotion of prevention services.

C. Program Development Section - The Program Development Section defines the direction for new Medicaid program services and supports the bureau in researching and implementing these services. The section researches federal regulations, studies Congressional and Legislative mandates and evaluates Medicaid services in other states to make recommendations to the division director. This office also works with other state agencies in the development and implementation of several programs including Case Management, Psychosocial Rehabilitation, Early Intervention, School-based services and Home- and Community-based waivers.

Office of Managed Care - The Office of Managed Care includes the Primary Care Network, a statewide primary care, case-management system which requires Medicaid recipients to enroll with primary physicians, clinics and pharmacies. These primary care providers serve as gatekeepers into the health care system and are responsible for monitoring the patient's use of health care services and eliminate the inefficient or inappropriate use of resources. The Office of Managed Care also oversees the division's transition from traditional fee-for-service Medicaid programs to managed Medicaid programs.

SECTION III

# MEDICAL ASSISTANCE DIVISION